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Editor
CHARLES H. KEENE, M.D.
University of Buffalo, Buffalo, N. Y.

Assistant Editor
GERTRUDE E. CROMWELL, R.N.
Denver, Colorado

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THE JOURNAL OF SCHOOL HEALTH

Deoted to the interests and advancement of school health service and instruction.
Your participation by membership is solicited.

Vol. XX DECEMBER, 1950 No. 10

SOME CURRENT MEDICAL PROBLEMS OF THE ARMY *

CLAUDE M. EBERHART, LT. COLONEL,
Medical Corps, U.S.A.

It is a privilege to discuss with you tonight some of the current military medical problems of the Army. In a sense, the Army Medical Service is a continuation of the school health program, since the vast majority of our men enter the military service directly from secondary schools and colleges. To this extent your problems become our problems, and our problems are either minimized or intensified according to whether the school health service has been adequate, inadequate, or just plain non-existent. Thus a review of some of the current medical problems of the Army should provide in some measure a critical evaluation of the accomplishments of school health programs in general and in this respect should be mutually helpful.

At the outset, it must be emphasized that the over-all result of such evaluation is not entirely depressing — in fact it is quite inspiring. The United States Army today is healthier than at any time in its history, and probably is the healthiest Army in the world. Particularly impressive is the noneffective rate, which is a measure of the strength of the Army not available for duty because of illness in hospital and quarters. In the last ten years this rate has decreased about 20 percent. Translated to actual numbers this means that on the average day in 1949, there were 4500 fewer troops off duty due to illness and injury than would have been the case had the 1939 rate still prevailed. During the same period the Army death rate due to disease decreased about 65 percent. In 1939 one man died of disease per 645 strength, whereas, in 1949 there was one death due to disease per 1900 strength. Although part of this saving of manpower is attributable to advances in therapeutic measures which have decreased the period of incapacitation for many diseases, much of this record may be credited to the fact that fewer men develop disease, as

* Address given at the Annual Dinner of the American School Health Association at St. Louis, Missouri, Wednesday, November 1, 1950. Officially released.

evidenced by the admission rate for disease which reached an all time low in 1949.

As much as we of the Army Medical Service should like to claim full credit for this remarkable record in the prevention of disease, we frankly must admit that part of the improvement is a result of the extension of school health programs in our country. It is undeniable that the health attitudes and hygienic practices of the young man entering military service today are far better than at any previous time. It is now rare indeed that we find a recruit who questions the value of bathing, wearing clean clothes, or brushing his teeth. These measures are generally established habits by the time a young man reaches military age. Most men now accept, and in fact expect, immunization, chlorination of drinking water, control of mosquito breeding and other protective activities which are carried out for them. Similarly we know that the recruit in World War II was taller and heavier and had fewer correctible physical defects than the recruit in World War I. Recruits have not always been so healthy or so receptive to preventive medicine practices, and it is believed that these improvements reflect to some degree the contribution of school health programs in general in the elimination of military problems.

Having examined the situation in general, we will now focus our attention on some of the details. The first item we meet is the results of Selective Service examinations. These have been recently the subject of much comment and discussion and, in any event, require some explanation. While the rejection rate of 49 per cent in recent examinations may appear shockingly high, it must be remembered that the men examined represent a highly selective group. The majority were between 22 and 25 years of age, and all were non-veterans without dependents. This means that many of them had been rejected on previous examinations during the last four to seven years. As such, the current group does not represent a random sample of our young adult male population, and no valid generalization either as to the physical and mental status of young men or as to the adequacy of standards for rejection can be based on the results of the recent examinations.

For our purpose, the results of Selective Service examinations during World War II are more to the point. Prior to the cessation of hostilities out of 16,000,000 men between the ages of 18 and 38 years who were examined, 30 per cent were found to be unfit for military service due to mental or physical reasons. The

four leading causes for rejection were: mental reasons present in 12 out of every 100 examined; musculo-skeletal in six of each 100; eye, ear, nose or throat disorders in three in every 100; and cardiovascular disease in two in 100.

In analyzing these data, there are two major considerations. The first is that the Selective Service examination results list only a single cause for rejection. Many of the men had more than one cause for rejection, but only the principal cause or that one first found is reported in the summary material. Likewise many correctible or non-incapacitating defects were present in those passed for military service. Another consideration is the fact that many of these defects may have developed in the intervening years after the individual left school. Thus, in no sense can the Selective Service figures be considered as anything more than a rough qualitative index of the type of defect not receiving sufficient attention in our present school health programs.

The quoted rejection rate for mental reasons includes only neuropsychiatric disorders for which there were 1,846,000 rejections. Psychoneurosis was the principal cause among white registrants, and psychopathic personality among Negro registrants. Of course, not all those rejected were unduly handicapped for civilian life, but on the other hand, all those unsuited for military service were not weeded out. There were one million neuropsychiatric admissions to Army hospitals during the war. Assuming that functional mental illness has its origin during the developmental years of the individual, one may conclude that there remains much to be done in the field of mental hygiene, particularly the formation of healthy mental attitudes.

Turning now to the next phase in the life of the recruit, we find another type of medical problem. The mental misfit, if he has passed the barrier of Selective Service examination, finds himself unable to adjust to the new environment and soon gets into administrative difficulties and often is discharged on administrative grounds. He then is no longer a military medical problem.

During training the foremost medical problem is infectious disease. Here there is fertile soil for epidemics. Large numbers of susceptible men are brought together and introduced to strains of organisms with which they have had no previous experience. By ordinary sanitary measures the enteric and insect-borne diseases are adequately controlled. The respiratory infections, however, at times defy our most intensive control efforts and outbreaks of illness do occur. One of the most serious of these is

streptococcic infection, which may be followed by rheumatic fever and eventually rheumatic heart disease. Prophylactic inoculation has not been proven to be of any value, and prophylactic doses of sulfonamide drugs or antibiotics cannot be used without some danger.

The problem of preventing rheumatic fever has been considered by the Commission on Streptococcal Diseases of the Armed Forces Epidemiological Board, and a recent large scale study sponsored by the Commission has resulted in a most promising measure.[1] Specifically, this consists of instituting penicillin therapy as soon as possible upon seeing a patient with a respiratory infection believed to be due to streptococci. The diagnosis is made on clinical findings only without awaiting confirmatory laboratory data. The criteria for diagnosis are sudden onset of sore throat with pain on swallowing, fever and other constitutional reactions, diffuse redness and edema of the soft palate, tonsils and oropharynx with discrete or confluent exudate and large or tender cervical lymph nodes. The treatment advocated consists of procaine penicillin G in oil with aluminum monosterate, 300,000 units on admission and repeated in 48 hours, and 600,000 units given 96 hours after the initial dose. Of 728 patients so treated only two developed rheumatic fever within 35 days as compared to 17 cases of rheumatic fever developing among 804 control patients. No significant reactions to the drug were encountered in this study.

We have in this finding a possible solution to a serious problem common to both the Army and the school health services.

After the first year of military service, infectious diseases do not constitute any great hazard to the soldier remaining in the United States. Accidental injuries, which have been plaguing him since his first day of training, become the principal medical problem. As the soldier is introduced to each piece of equipment he is instructed in the safety precaution necessary to its use. Throughout his service he is subjected to a well-organized safety program, and all available means are used to emphasize personal responsibility in the avoidance of accidents. Despite all this, injury last year accounted for about 900,000 man days lost within the Army stationed in the United States.

When troops are sent overseas, the medical problems multiply. First they must be indoctrinated concerning, and immunized so far as possible against, the unusual disease hazards of the world area to which they are going. Secondly, there is the crowd-

ing and mixing of susceptible with infectious individuals aboard transports. Third, there are the various foreign quarantine regulations of various countries which must be observed. And in the fourth place are the changes in ordinary habits of individuals which are required for adaptation to unusual environment, such as the tropics or the arctic.

In order to illustrate these problems we will consider the situation in Korea. We knew from previous experience in that country that the terrain is rugged, and the climate varies from extremely hot summers with heavy rainfall to winters which are about as cold as those experienced here in St. Louis. Except in large urban centers, sanitary conveniences as we know them simply do not exist. In addition to the respiratory infections, including those of streptococcal origin, diarrhea and dysentery are fairly common disease hazards. Malaria is highly endemic among the native population, and mosquitoes can breed readily from April through October. A highly virulent form of smallpox is endemic and has been epidemic, the latest outbreaks occurring in 1946 and 1948. A cholera outbreak occurred as recently as 1946, and the disease must be considered a potential hazard. Typhoid fever is common among Koreans, and louse-borne typhus fever occurs sporadically. Japanese encephalitis occurs probably every summer, and last year there was a sizeable outbreak. Venereal diseases are far more prevalent than in this country. And finally for troops in combat there are the adverse effects due to extreme heat and cold. This was the picture we had in mind when the North Korean Army invaded Southern Korea in June.

The first problem in connection with the Korean invasion was the evacuation from South Korea of women and children dependents of American, Allied and United Nations personnel. This began almost immediately, and the first evacuees arrived in Japan on the 27th of June. Before the operation was ended more than two thousand persons were evacuated to Japan without any unusual incident. Many of these had no possessions other than the clothes they wore. Some were pregnant women. The Army provided food, accommodations, medical care, and arranged transportation, and the Red Cross furnished financial aid and emergency communications for contact with families in the U. S. and elsewhere. Most of these evacuees were returned to the States, many by air.

A few of the evacuees required hospitalization in Japan for ordinary illnesses or pregnancy. Among the first to arrive was a

one-year-old American child who was thought to have pneumonia. The condition of the child improved for a time, but one week later it suddenly became worse and a definite clinical diagnosis of smallpox became apparent. This was on July 4th and subsequently the diagnosis was confirmed.

Many of the persons who had been in possible contact with the child on the evacuation ship were scheduled for evacuation by air to the U. S. prior to July 12th, and their further travel apparently could not be delayed without considerable difficulty. These persons, as well as all other contacts with the child, were immediately revaccinated and prior to embarkation were examined for freedom of signs or symptoms of infectious disease. All intermediary and final airports of destination were alerted by radio, and the passengers were appropriately handled at each stop. The Public Health Service was notified, and Public Health Service Quarantine Officers accompanied Army medical officers in meeting and examining the contacts as they arrived in the U. S. Insofar as is known, not a single case of smallpox was introduced into this country as a result of the evacuation of these persons.

The next problem was that of providing for the United Nations troops adequate protection against the normal disease hazards of the country. American troops were instructed in the individual measures they were to observe in protecting themselves. Other U. N. countries supplying troop units were requested to do likewise. Immunizations had to be given. These consisted of smallpox vaccination prior to embarkation regardless of time of last vaccination, active immunization against tetanus, and immunization against typhoid fever, typhus fever and cholera within six months of embarkation. Again other U. N. countries cooperated in meeting these requirements. In addition all troops insofar as was possible were immunized against Japanese encephalitis if they arrived prior to September 15th. Enormous quantities of water purification tablets, chloroquine for the suppression of malaria, insecticides and insect repellents had to be procured, shipped and distributed to all troops in combat.

What has been the effect of these actions? It is not possible to answer this question quantitatively. However, it is known that there have been no serious outbreaks of disease among military units in Korea. Of those diseases listed as hazards in that country, bacillary dysentery and common diarrhea have ranked high in numbers of cases, malaria has occurred about as frequently as the diarrheal disorders, and Japanese encephalitis while not near-

ly as prevalent is considered a problem because of the serious nature of the disease. While vaccination against Japanese encephalitis does decrease susceptibility to some extent, it must be supplemented by mosquito control measures. In combat these, as well as the sanitary measures for the prevention of diarrhea, must be exercised by the individual for his own protection.

With the cessation of hostilities, it is expected that diarrheal disorders, malaria and Japanese encephalitis will become less prevalent and that the incidence of venereal disease, which has been low, will rise precipitously. This assumption is based upon previous military experience. Whenever the collective security afforded by the sanitary services available in garrison can be applied, the incidence of enteric and insect-borne diseases become of negligible importance, and respiratory and venereal infections become more prominent.

In coming back to our original purpose, it may well be asked how does this account of military medical problems provide any evaluation of school health programs? Briefly, the relationship lies in the general observation that those disease prevention measures such as immunization and inspection, which did not require active participation on the part of the individual were highly effective; the failures occurred in connection with preventive practices that had to be applied by the individual for his own protection. In our teaching we have failed to develop in the individual the necessary attitude required to induce him to put into practice, at some inconvenience to himself, those measures which he has been taught will protect his health.

The lack of proper health attitudes, particularly the recognition by one of his responsibility for his personal health, has been a problem of the Army Medical Service for many years. Our particular aim is the conservation of manpower. In achieving this aim, we have been fairly successful when we can control the activities and environment of the soldier. On the other hand, when he is on leave or pass, he is independent of this control and is free to act in a manner suitable to himself.

One of the hazards of free time for the soldier is venereal disease. For years the Army tried to control these diseases by freely providing prophylactic facilities. As long as the treatment of these diseases was dreadful to contemplate, and as long as there was a reasonable possibility of severe and disabling complications, the prophylactic approach was fairly effective. With the advent of penicillin, however, fear of the venereal diseases was abolished.

At the same time the use of prophylactic facilities diminished and the incidence of venereal disease increased.

The negative attitude, based on fear, had failed us. It was then decided to stress sexual continence as the chief venereal disease control measure. This decision entailed the development of a general healthy moral and mental attitude among all personnel and group acceptance of these standards. For this purpose the character guidance program was initiated with the specific aim of developing in the individual a spirit of service and a sense of pride in the proper performance of duty, an awareness of individual responsibilities and a recognition of the obligations and opportunities inherent in the military service. This program is broad in its application, positive in its approach and embraces all the activities of the soldier. In a sense, it is a continuation of good parental guidance, in that it encourages the development of individual moral responsibility and self-discipline. If effective it will result in excellent soldiers and citizens, and in doing so will establish, as a by-product, attitudes that will encourage the practice of continence.

The major obstacle to this program lies in those men whose previous training has fostered an attitude of self-indulgence. They actively rebel at the thought of any sort of individual responsibility or discipline, and adversely affect group acceptance of healthy attitudes by means of barrack room discussions. Apparently we need to center attention on these individuals within the military service in an attempt to change their attitude and within the school to prevent the development of the anti-social postures. Naturally, the early inculcation of healthy thinking in children is easier than changing attitudes of adults.

The lack of awareness of individual responsibilities for health has not seemed important in civilian life until within recent years. Public health activities have been directed largely toward the control of the communicable diseases, which have been amenable to community-type action. Now the control of heart disease, cancer, accidents, and chronic illness is assuming more importance. Action on the part of the individual is required if the toll taken by these conditions is to be reduced. In planning for civil defense we are assuming that major catastrophe will occur. This can mean disruption of all sanitary services within a stricken community. In such instance the next line of defense against the spread of disease is the application of ordinary individual precautions. If these are adopted and practiced by everyone, further confusion

due to epidemics will be averted; if individual responsibility is not accepted the chaos may be compounded to such an extent that panic will result. Clearly there is now an important need for such attitudes as will impel individuals to take an active role in the promotion of their own health and that of the community.

In summary, a review of some current military medical problems indicates that the school health programs have been successful in aiding children to grow into healthy adults, who will participate passively in community-type health programs. The health instruction phase of the school health programs, while doing a reasonably creditable job in imparting knowledge, has not succeeded entirely in helping the individual translate that knowledge into healthy attitudes and practices. This is a fact which must be faced by all of us in both military and school health work. Our task now is "to guide people to do for themselves that which is good for their own health and that of others in this and future generations."[2]

(1) Denny, Floyd W., et al: Prevention of Rheumatic Fever, JAMA, *143*, 151-153, May 13, 1950.

(2) Kilander, H. F.: Trends in Health Education in Secondary Schools, *School Life, 31*, page 6, April, 1949.

* * * * *

Sunlight and Tuberculosis,—To the Editor:—What are the effects of exposure of patients with pulmonary tuberculosis to sunlight? Are the sun's rays of any therapeutic significance in quiescent pulmonary tuberculosis? Do they exert any deleterious effects? M. D., Kentucky.

Answer:—The physical effect of the sun's rays on the skin is well known. Among other things there is local hyperemia, followed by a slight leukocytosis, and a chemical change of some of the fats and lipids to vitamin D. These changes are beneficial to patients with quiescent tuberculosis, provided they can be acquired without burning, the chief deleterious effect, which is toxic and may cause an exacerbation of the disease. Great care should be used in exposing patients in the acute febrile disease to the sun's rays, as harm may result from overstimulation even without burning. The sunlight should be prescribed like a drug until a proper protective tan is acquired. The first exposure should be for only a few minutes, then each day increase the exposure gradually until the tan is well developed. In sensitive skin it is well to shield the patient with some protective material like paraaminobenzoic ointment. Journal American Medical Association, November 4, 1950, p. 887.

HEALTH VOLUNTEERS IN THE SHOREWOOD HEALTH PROGRAM

By IRENE H. HUGUNIN, R.N.
Health Co-ordinator, Shorewood (Wis.)

Shorewood health volunteers, who in 1949 contributed 6,000 hours of their time in the interests of home and school health, are now preparing to expand the scope of their activities to include the needs of the civil defense program.

Volunteers will take courses in Red Cross first aid and home nursing to fit themselves for care of the sick and injured in case of a war emergency. They have pledged themselves to serve in the first aid civil setup of their respective schools, their husbands to serve as alternates in first aid and as stretcher-bearers.

This is just another instance of the community contributions made by the health volunteer group, which is directed by the Shorewood Health Department and sponsored by the Parent-Teacher organizations of the four local schools. The group is probably unique in that its work is carried on through the schools, and that a complete course of training is given before members qualify for active service. An outgrowth of individual volunteer services, the health volunteers became a school and home project in 1945. The idea has spread from Shorewood to other parts of the state and thence to communities in other states.

Parent participation in the health program has proven invaluable in promoting better health attitudes and understanding in the community. High standards have been set, sound elementary basic training given. Activities are purposeful — some planned with leeway for initiative, others to conform to rigid policies and ethics. Qualified speakers have been used to stimulate interest.

It is well to remember that the volunteer needs to be inspired and impressed by the quality of work done by the professional staff, as well as by their professional decorum. In turn, the volunteer has a high responsibility to live up to the prescribed standards and to keep her place as an ethical, loyal lay participant dedicated to the promotion of health for all.

The public health nurse in the school and community of Shorewood performs services that are difficult to measure objectively. She offers health supervision, guidance and counseling to individuals and families at home, at school and in the community; she conducts, assists with or supervises such health examinations as physical, dental, immunization, testing of eyes, hearing, weighing and measuring; she maintains and evaluates cumulative rec-

ords; she participates in educational programs and shows leadership in promoting optimum health for all.

Categories of disease which may be considered preventable and applicable to a school and community health educational program are: communicable disease, tuberculosis, rheumatic fever, nutritional diseases, allergy, improper growth and development of children, dental disease, mental and nervous disorders, maternity complications, hereditary disorders, certain types of cancer and non-degenerative heart disease. Safety is also stressed.

The health volunteer's work is varied. She makes out individual weight cards, weighs and measures children three times each year and records average weights once a year. (This activity is organized and planned by the volunteer chairman with the assistance of the public health nurse, who procures the children. The volunteer does not run around the school or interrupt classes.) She makes out a hearing card for each child annually and gives "screening tests" with the Maico machine. (The public health nurse evaluates the cards and marks necessary retests, which are done subsequently by the professional staff.)

She assists in the annual TB testing program by preparing cards, checking previous records, obtaining the signatures of parents of the new students in the school. (The result has been 99% participation in the program.) She may also compile statistics, arrange posters and health exhibits, entertain waiting children, make the ill child comfortable until home transportation is arranged, act as hostess to visitors if the health staff is busy, and the like.

The outstanding project of the health volunteers is the summer round-up of four-year-olds who will enter kindergarten that Fall. All mechanics — rounding up the children by cards and home calls, making of appointments, etc. — is done by the volunteer. She is supported by the policy committee, consisting of school and health administrators and their staff.

The volunteers' main community project is the March of Dimes. House to house canvassing and clerical work are performed.

The local organization of health volunteers is approved as a policy by school and health administrators; it is sponsored by school organizations; it is accepted as an important part of an integrated health program by the health and school staffs; it is endorsed as a sound program through good interpretation and the maintaining of uniform standards and policies by all concerned — the school, the health staff, the volunteer.

A good average attendance is required at all meetings, classes

and demonstrations. The health staff is responsible for program-planning in training and class instruction and for coordinating the work of the volunteers when they are working in the school. Good leadership is necessary to promote and sustain a program of lay participation.

The volunteer must be a parent of a child in the school. She must have an aptitude for, and definite interest in health promotion. She must be able to serve at least four hours per month and have a good average in class attendance. Her health must be good and she must have an annual x-ray. She must pass precision tests before being permitted to give them.

She takes this modified Hippocrates' oath: "I, ————....., as a Shorewood Health Volunteer, do solemnly promise to loyally support our community health program and its professional workers. I further promise to hold sacredly, confidentially, family affairs coming to my knowledge while performing my duties as a volunteer health assistant."

The volunteer is recruited from the school parent organization — the PTA in the elementary public schools; the school and home association of the parochial school; the music parents' group of the high school. Her training includes 16 hours of formal class attendance and as much individual instruction in precision testing as is necessary.

Lectures include discussions on the community in general (public officials and facilities; how the public health program is integrated with all village departments and schools; the part each plays in endorsing and setting policies for a growing functional program of "health for all"); discussions of the health department, its program reaching different age groups and its special services; discussions of the school health program — its routines, testing, in-service training, etc.; discussions of medical and school ethics and public relationships; discussions of how to handle children, individuals and in groups; discussions of preventable diseases; discussions on understanding the function of the public health nurse in the school and community; discussions of general routines and procedures, such as keeping records; discussions of the hard of hearing child and how testing is conducted and organized.

In addition, qualified outside speakers brief the volunteers on the county and state public health setups, on membership in the lay section of the S.O.P.H.N. and on welfare facilities in Milwaukee county.

Demonstrations of the use of the Maico machine are given to each group of volunteers in their own school. Most other routines

are taught to the volunteer as she works.

The health chairman in each school is selected for her integrity, leadership, reliability and quality of service. Besides completing the required training course, she must have served as a volunteer for at least one year and have been chairman or co-chairman of a summer round-up. Her selection is considered by the president of the school organization, the principal of the school and the supervising nurse. The appointment is made by the school organization's president.

* * * * *

Criterions of a Testing Program (Condensation), Arthur E. Traxler*, (1) Is the testing program comprehensive? (2) Does the testing program include all pupils in the school? (3) Are the tests given at regular intervals? (4) Are the tests well timed? (5) Are the tests in the school's testing program comparable? (6) Do the tests used agree with the objectives and the curriculum of the schools? (7) Are the specific tests carefully chosen? (8) Are the tests carefully administered to each group? (9) Are the tests scored accurately? (10) Are the test results interpreted in terms of appropriate norms? (11) Are the test results quickly reported to teachers and counselors in understandable terms? (12) Are the test results recorded on individual cumulative record forms? (13) Is a definite attempt made to relate the test scores to other kinds of information? (14) In addition to the regular testing program, is there provision for special testing as needed? (15) Does the school have an in-service program for educating teachers in the use of test results?

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* Arthur E. Traxler is Associate Director of the Educational Records Bureau, New York City. Reported from the Clearing House, XXV (September, 1950). 3-7.

EVALUATION OF HEALTH HABITS AND ATTITUDES

By WILLARD WALTER PATTY
Dean, School of Health, Physical Education and Recreation
Indiana University

It is generally recognized that right habits and attitudes are essential to healthful living. Can they be measured successfully?

Health habits unmeasurable by pencil-and-paper tests. An explanation as to why pencil-and-paper tests of habits rate low in validity has already been presented. It would be possible, if considered desirable, to develop a test of knowledge of right health habits which people should form, but such a test would not be a valid measure for health habits actually practiced.

Habits evaluated by observation. It is considered to be possible to accumulate observation notes of health practices of pupils. In order to serve as a satisfactory basis for evaluation such observations must be systematic. They should be equivalent as to number for all pupils rated. The observations, to be comparable, should include the same variety of health living situations for all pupils evaluated.

Attempts to measure health attitudes. The importance of health attitude outcomes of health education has been recognized by health educators in course of study construction. One published summary,[1] based upon an investigation of published courses of study, includes thirty-four specific attitudes as desirable outcomes in the elementary grades. The difficulty of accurate pencil-and-paper methods of testing such attitudes is suggested by verbs used, such as: enjoys, appreciates, tries, desires, fears, likes and cooperates. Also it is apparent that it is not easy to develop objective questions which will measure attitudes expressed thus: is conscious of poor ventilation, has courage etc., has concern etc., is sympathetic etc., is courteous, is cautious, and has pride.

A considerable number of attempts have been made to construct pencil-and-paper tests of health attitudes. The selected test, inventory, and scale presented here represent three different approaches.

A Health Awareness Test[2] has attempted to secure attitude reactions to health situations and principles by health story settings. A School Inventory[3] provides for "yes" and "no" responses

(1) Patty, Willard Walter: Teaching Health and Safety in Elementary Grades. pp. 81-84, Prentice-Hall, Inc., New York. 1948.
(2) Franzen, R., Derryberry, M., and McCall, W. A.: Health Awareness Test, Bureau of Publications of Columbia University, California, 1933.
(3) Bell, Hugh M.: The School Inventory. Stanford University Press, Stanford University, California, 1936.

to questions of an emotional health attitude nature. A Health Attitude Scale[4] invites favorable, neutral, or negative responses to statements concerning health policies. It is a question as to the level of validity and reliability of such measuring instruments. It would seem, however, that professional efforts along these lines might well continue.

At present the most practical suggestion for evaluating health attitudes of pupils is for accumulation of teacher observation records, rather than construction of health attitude tests. One author states[5]: "If such notations are filed habitually in the personnel folders of pupils, they may constitute an important practical evaluation of attitudes."

(4) Byrd, Oliver E.: Byrd Health Attitude Scale. Stanford University Press, Stanford University, California, 1940.
(5) Patty, Willard W.: "Evaluating Health Education Outcomes." Journal of School Health. p. 37, February, 1949.

SELECTED REFERENCES

1. Bell, Hugh M.: The School Inventory. Stanford University Press. Stanford University, California, 1936.
2. Byrd, Oliver E.: Byrd Health Attitude Scale. Stanford University Press. Stanford University, California, 1940.
3. Franzen, R., Derryberry, M., and McCall, W. A.: Health Awareness Test. Bureau of Publications of Columbia University, New York, 1933.
4. Patty, Willard W.: "Evaluating Health Education Outcomes." The Journal of School Health, February, 1949.
5. Patty, Willard W.: *Teaching Health and Safety in Elementary Grades.* Prentice-Hall, Inc., New York, 1948.

* * * * *

Cardiac Survey,—Dr. George Maresh reported the final results during the summer of the cardiac survey among our sixth grade children. Cardiologists examined 1,810 pupils and found 18 cases of heart disease. Four of these were congenital and the rest presumably due to rheumatic fever. Of the later, about half of the children gave any history of rheumatic infections or minor streptococcic infections. Of the 18 cardiac defects, three were not known to the school health service, one being new to the schools last year and the other two being recorded with negative heart finding in 1947 and in 1948, when they were last examined by school physicians.

** From Bulletin to School Nurses, Denver, Colo.

* * * * *

Educated?—The educated person understands the basic facts concerning health and disease, protects his own health and that of his dependents, and works to improve the health of the community." Educational Policies Commission.

RELATIONSHIP OF HOUSING TO INCIDENCE OF UPPER RESPIRATORY INFECTION IN NEW HAVEN GRADE SCHOOL CHILDREN

ABRAHAM GELPERIN, M.D., DR. P.H.*

Absenteeism in schools is a major problem for both Departments of Education and Public Health. Results of an evaluation of causes of absenteeism in New Haven schools during 1948-49 (1) were compared with those of a similar investigation made in 1927-28, (2) *and it was ascertained that*:

1. Absentee figures (based on absence of three or more school days) were 66.3 per cent of the student population for 1948-49, and 48.9 per cent for 1927-28. In 1948-49, there were 25,608 students attending school for 180 days (4,609,080 pupil days); in 1927-28, 33,700 pupils attended school for 186 days (6,270,000 pupil days).
2. During 1948-49, there was a marked increase in absence due to upper respiratory infections from 53.8 per cent in 1927-28 to 62.7 per cent. However, a significant decrease in days absent per case was noted.
3. The incidence of the childhood communicable diseases was similar; but a marked decrease was observed in days absent per case.
4. Sex continued to be a negative factor in both incidence and duration of diseases.
5. The highest incidence of illness occurred in younger age groups in both studies; however, morbidity was consistently higher in each age group in 1948-49. This increase was greatest in older children, starting about age ten.

Three factors have probably played a role in increasing school absence in 1948-49: (1) better screening by school health personnel, including teachers; (2) increased parental attention to the significance of mild upper respiratory infection as possible precussor of childhood communicable disease; and (3) increased parental attention to early medical care for all illness. The role of each of these factors is difficult to evaluate.

The increased incidence of disease in older school age groups (10 - 14) has been observed by other workers in communicable disease control. This important shift in age specific illness rate must modify communicable disease control and school health programs.

* From New Haven Health Department and Department of Public Health, Yale School of Medicine.

The possible influence of housing upon absenteeism resulting from upper respiratory infection has been evaluated for the 1948-49 survey. New Haven was a test area in 1940 - 1944 for the development of a technic of inspecting and evaluating health qualities of housing, as well as for a system of recording such data. The city wards were studied and divided into five categories of housing quality. A re-evaluation in 1950 verified the validity and usefulness of the original information.

Public grammar schools were separated into five categories, determined by the status of housing in the contiguous school district. Parochial, junior and senior high schools were excluded because their attendance is not limited to a closely knit area: the age group studied was thus limited to 5-13.

Table I presents the number of schools, population and pupil days in each of three housing categories. Table II shows the incidence of upper respiratory infection for each category.

TABLE II

Incidence of Upper Respiratory Diseases in New Haven Public Grammer School Children for Each Housing Category.

	HOUSING CATEGORIES		
	I	II	III
Cases of U. R. I.	2705	2118	2155
Days Absence	15973	12194	11981
Days Per Case	5.90	5.76	5.56
Cases Per Pupil	0.63	0.55	0.45
Cases Per 1000 Pupil Days	3.51	3.05	2.52

A lack of relationship between quality of housing and incidence of upper respiratory disease is evident. The number of cases per 1,000 pupil days increased with better housing; and duration per case shows a similar trend. Sydens tricker in Hagerstown (4) and Paton and Findlay (5) and Smith (6) in Scotland have made similar studies. Their findings also failed to corroborate the statement that poor housing means poor health. However, their findings clearly show that any single factor among the many which are involved in modifying the incidence of disease (e.g., size of family, degree of crowding, economic status, level of intelligence and education, availability of medical facilities, scope of Health Department activities, etc.) must be considered only in relation to all other factors: thus related, they

found housing to be of minor importance. The New Haven absentee study, though it did not consider the many related factors, corroborated their findings with respect to housing. Investigation in this field must be delineated in terms of specific disease category, as well as age group (4, 5, 6).

Several factors may explain the increase in both incidence and duration of upper respiratory infection in areas of good housing: e.g. (1) better medical care; (2) higher per cent of working mothers in lower groups; and (3) greater parental solicitude. The latter factor is probably not valid in this study, since an absence of three or more school days usually indicates actual illness. However, these three factors are evidently generally accepted, since questioning of workers in the field uncovered unanimity of opinion on a speculative basis. Scientific evaluation of their relative importance is difficult. Paton and Findlay (5) discuss another factor which they term "maternal efficiency" and consider it of prime importance.

The New Haven study indicates that the quality of housing, per se, does not adversely influence the incidence of upper respiratory disease in public grammar school children.

TABLE I

Number of Pupils and Pupil Days for Each of Three Categories of Housing for New Haven Public Grammar School Children.

	I Superior—Good	II Satisfactory	III Unsatisfactory—Slum
Number of Schools	13	12	12
Number of Pupils	4,269	3,855	4,744
Number of Pupil Days (180 School Days)	768,420	693,900	853,920

BIBLIOGRAPHY

1. Linde, J. I., Gelperin, A., Granoff, M.A.: Causes of Absenteeism in New Haven School Children, a Twenty-One Year Followup. Public Health Rep. In press.

2. Wilson, C. C., Hiscock, I. V., Watkins, J. H., Case, J. D., Price, J. L.: A Study of Illness Among Grade School Children, Pub. Health Rep. *46*:1801, 1931.

3. Sydenstricker, E.: Economic Status and Incidence of Illness, Public Quality of Housing, Am. Pub. Health Ass'n. Comm. on the Hygiene of Housing, 1945.

4. Sydenstricker, E.: Economic Status and Incidence of Illness, Public Health Rep. *44*: 1821, 1929.

5. Paton, D. N., Findlay, L.: Poverty, Nutrition and Growth, Medical Research Council Special Report 101, 1926. H.M. Stat. Off. London.

6. Smith, C. M.: Housing Conditions and Respiratory Disease, Medical Research Council Special Report 192, 1934. H.M. Stat. Off. London.

DUTIES OF PROFESSIONAL HEALTH EDUCATORS *

J. KEOGH RASH
Assistant Professor of Health, Physical Education and Recreation, School of Education
University of Indiana

Professional activity of groups meeting in conferences and workshops in recent years for the purpose of determining curricula for various types of health educators, has given evidence of need for a sound basis for determining such curricula.

It is immediately acknowledged that such conferences have rendered a valuable service by way of suggesting patterns of training for prospective health educators. However, it is the contention of the writer and others that a knowledge of what the health educator actually does would make possible a more adequate planning of the curricula for various types of health educators.

As a result of this conviction, the author personally interviewed 75 selected health educators for the purpose of determining their major duties or activities. In addition to the work of identifying the duties of the health educators, the study included an evaluation with a view to determining the importance and the difficulty of the duties. The present article is concerned with the results of identifying the duties of the health educators.

The health educators who participated in the study were selected on the basis of established criteria. They work and reside, for the most part, in the states of Illinois, Indiana, Kentucky, Michigan and Ohio.

The number of the various types of health educators represented in the study is as follows: High School—27, College—15, Official Agencies—13, Non-official Agencies—13, and Health Coordinators—7. The justification for drawing conclusions based on a limited number of interviews rests in the job analysis technique.

As a result of personal interviews with the 75 health educators, it was possible to compile the list of 150 duties performed by them. These duties were grouped into the following blocks or major areas: General Education, Health Education, Health Service, Supervision, Public Relations, Counselling, Organization,

* Based on *An Analysis of the Duties of Selected Professional Health Educators*, a dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Health and Safety, School of Health, Physical Education and Recreation, Indiana University, Bloomington, 1949.

Administration, Community Activities and Self-Improvement. The term "duty" as used herein, refers to tasks performed in carrying out the work of one's profession. It is used in a broad sense and does not refer to detailed actions involved in performing a task.

In curriculum-planning it seems wise to give special attention to the needs of the health educators, as evidenced by the kind of duties they are most commonly expected to perform. These are suggested in the list of duties reported by all of the health educators of each type.

Some comparisons of the kinds of curricula needed for the professional preparation of health educators are suggested by the blocks of duties which are most characteristic, or those least so, of each type of health educator. These are augmented by the lists of duties which all of the health educators have in common and those which are unique to each type. These data are further supported by significant coefficients of correlation of the ranking of the blocks by the different types of health educators.

The above points are considered in the following discussion:

Duties Universally Reported

One duty, "attend professional conferences," was reported by all 27 of the high school health educators.

Twelve duties were reported by all 15 of the college health educators. These are:

Select or recommend books for library.
Plan courses to be taught.
Prepare objective type examinations.
Teach health classes.
Select or recommend textbooks.
Select or recommend reference books.
Determine academic grades or marks.
Use visual aids.
Select visual aids for use or purchase.
Member of professional association.
Attend professional conferences.
Study for professional growth.

Seven duties were reported by all 13 of the official health educators. These are:

Select or recommend reference books.
Work with official of non-official agencies.
Work with officials of official agencies.
Make talks to special groups.

Counsel teachers and administrators on health problems.
Carry on correspondence.
Attend professional conferences.

Four duties were reported by all 13 of the non-official health educators. These are:

Work with officials of non-official agencies.
Work with officials of official agencies.
Make talks to special groups.
Carry on correspondence.

Twenty duties were reported by all seven of the health co-ordinators. These are:

Talk at institutes.
Assist in health workshops.
Select visual aids for use or purchase.
Plan educational programs for laymen.
Work with officials of non-official agencies.
Work with officials of official agencies.
Serve on state committees.
Make talks to special groups.
Organize citizens' committees.
Promote coordinated school-community health programs.
Counsel teachers and administrators on health problems.
Promote special projects (testing, detection, etc.)
Carry on correspondence.
Serve on health committee.
Serve as chairman of school health committee.
Serve as health co-ordinator.
Conduct or assist in community surveys.
Member of professional association.
Attend professional conferences.
Study for professional growth.

It is interesting to note that high school and college health educators are commonly called upon to teach subjects other than health education. High school health educators report teaching 11 subjects other than health. The most common of these are physical education and driver training. College health educators also report teaching 11 subjects other than health. The most common of these are physical education, anatomy and physiology. There is small agreement in the course taught by these two types of health educators. Physical education and safety are the only subjects they have in common.

On the basis of the number of duties performed by all of the

health educators of each type, the health co-ordinators show the highest degree of uniformity in their work, with 20 duties being reported by all seven of them.

Number of Duties Performed

The greatest number of duties reported by a single health educator is 97. This number was reported by both a high school and a college health educator. The smallest number is 19, reported by a non-official health educator. These data, along with some simple measures of distribution and central tendency are shown in Table I.

TABLE I. NUMBER OF DUTIES REPORTED BY INDIVIDUAL HEALTH EDUCATORS.

	High S.	College	Official	Non-Off.	H. Co-or.
High	97	97	80	81	93
Low	37	48	34	19	29
Range	60	49	46	62	64
Mean	66	66	58	45	65
Median	65	63	60	45	68
Mode	59	57 68	35 80	55	None

For the purpose of comparing the work of the various types of health educators, the top 25 per cent (to the nearest percentage division) of all duties reported by each type were selected. A study of these duties reveals that the following seven duties were reported in common by health educators of all types.

Duties Reported by All Types of Health Educators:

Select or recommend books for library.
Use visual aids.
Select visual aids for use or purchase.
Work with officials of non-official agencies.
Member of professional association.
Attend professional conferences.
Study for professional growth.

By contrast, the following duties were unique to each type of health educator:

Duties Unique to High School Health Educators:

Select standardized tests.
Conduct physical examinatons.
Supervise health and sanitary conditions of facilities.

Supervise gymnasium apparatus for health and safety.
Make recommendations regarding repair of equipment.
Conduct recreational projects.
Discipline students.

Duties Unique to College Health Educators:
Prepare syllabi for courses.
Carry on daily health observations.
Advise teachers in selection of textbooks.
Counsel students on economic problems.
Discuss results of health examinations with students.
Recommend purchase or construction of facilities.

Duties Unique to Official Health Educators:
Make school health surveys.
Participate in recreational activities.

Duties Unique to Non-Official Health Educators:
Make or organize radio broadcasts.
Serve on committees of non-official agencies.
Serve on regional committees.
Participate in raising money for institution or agency.
Employ professional personnel.
Employ clerical personnel.
Prepare budget.
Serve on community health council.
Member of service club.

Duties Unique to Health Co-Ordinators:
Serve on curriculum committee.
Organize citizens' committees.
Serve as chairman of school health committee.
Make periodic health reports.

It is worthy of note that certain duties are unique to the high school and college health educators and that other duties are unique to the official and non-official health educators and health co-ordinators. These unique duties furnish a basis for comparing the work of the two larger groups.

Duties Unique to High School and College Health Educators:
Teach classes other than health.
Plan courses to be taught.
Prepare objective type examination.
Teach health classes.
Prepare written lesson plans.
Determine academic grades or marks.

Administer first aid.

Make recommendations regarding purchase of equipment.

Counsel students on social problems.

Advise concerning grading.

Duties Unique to Official and Non-Official Health Educators and Health Co-Ordinators:

Talk at institutes.

Assist in health workshops.

Plan educational programs for laymen.

Contact different school systems.

Write or edit material for newspapers, magazines, radio, etc.

Counsel citizens on health problems.

Promote special projects (testing, detection, etc..).

Assist with institutes.

Conduct or assist in community surveys.

An examination of the pattern of work of each type of health educator reveals the rank order of the blocks as shown in figures 1 to 5. The rank in this case is determined by the ratio of the number of mentions to the possible frequency of mentions or the percentage of possible frequency of mention. In each instance the blocks are arranged in order of decreasing value with the block claiming the highest percentage ranking at the top. In subsequent discussion the blocks which clearly outrank the others are used as representing the chief characteristics of the health educators. Since the block "Self Improvement" ranks first with all types of health educators, the discussion which follows will give attention to the other blocks.

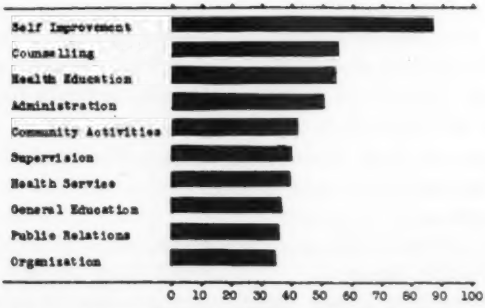

Fig. 1. Per cent of possible frequency of mention of items in each block by high school health educators

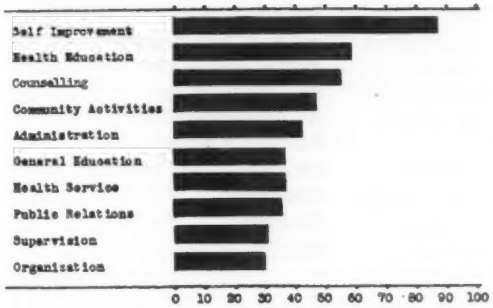

Fig. 2. Per cent of possible frequency of mention of items in each block by college health educators

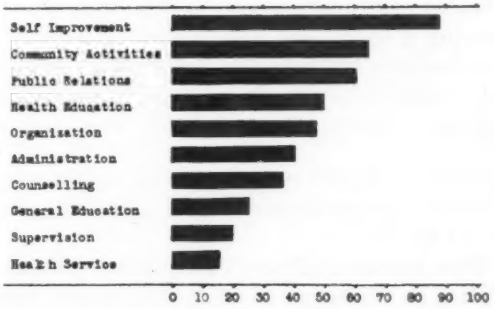

Fig. 3. Per cent of possible frequency of mention of items in each block by official health educators

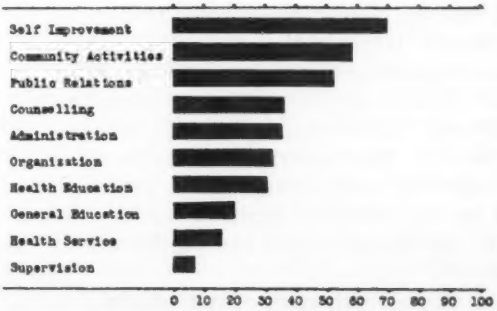

Fig. 4. Per cent of possible frequency of mention of items in each block by non-official health educators

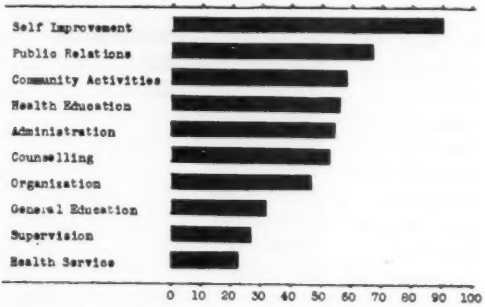

Fig. 5. Per cent of possible frequency of mention of items in each block by health co-ordinators

The blocks which are most characteristic of each of the various types of health educators are as follows:

High School. Counselling and health education, with administration playing a prominent role. (Fig. 1)

College. Health education and counselling. (Fig. 2)

Official. Community activities and public relations. (Fig. 3)

Non-official. Community activities and public relations. (Fig. 4)

Co-ordinators. Public relations, with community activities, health education, administration, and counselling following in close order. (Fig. 5)

These data clearly indicate that public relations occupies a prominent place in the work of the public health educators while school activities, such as instruction, occupy the most prominent positions among school health educators.

In contrast to the blocks which characterize the work of the health educators, those which least characterize the duties of each type are as follows (lowest block given first):

High School. Organization and public relations. (Fig. 1)

College. Organization and supervision. (Fig. 2)

Official. Health service and supervision. (Fig.3)

Non-official. Supervision and health service. (Fig. 4)

Co-ordinators. Health service and supervision. (Fig. 5)

Rank difference correlations of the ranking of all of the college blocks by the different types of health educators reveal coefficients of correlation which are significant at the 1 per cent level as follows:

Rank of official with rank of non-official ..... P= .8677

Rank of non-official with rank of co-ordinators ..... P= .8910

Rank of high school with rank of college.....P= .9223
Rank of official with rank of co-ordinators.....P= .9516

Other rank difference correlations failed to reveal significant relationships. For example, the next most significant relationship exists between the college health educator and the health co-ordinator, yet the coefficient of correlation between their rankings is .5013, which is not significant at the 5 per cent level.

A study of these data leads to the conclusion that high school and college health educators make up a group of school health educators while official and non-official health educators and health co-ordinators make up a group of public health educators. While the pattern of work of these two larger groups differs considerably, there is still a large area within which they have duties in common. This is evidenced by a rank difference correlation of P= .6394 when the gross ranking of blocks by school health educators is correlated with the gross ranking of blocks by public health educators.

A discussion of the evaluation of the duties by the health educators must be reserved for later consideration.

* * * * *

The Common Cold,—The September 23rd issue of the J.A.M.A. featured a six page article on "Some Problems of the Common Cold," with the following conclusions:*

"The common cold is a specific virus infection which may be thwarted by resistance of the host or promoted under some conditions by exposure to cold or by other influences. Infection may come from without, from a patient or perhaps from a carrier, and carriers probably may catch cold from autoinfection. There is no solid evidence that the true cold is influenced by antihistaminics or antibiotics, nor is there any reliable method of prevention. Treatment remains symptomatic—rest, safeguarding, local applications and general sedatives. The true cold is often confused with the various forms of truamatic rhinitis, which are not the common cold at all and which may be amenable to various forms of suitable treatment, such as antihistaminic or antibiotic therapy. Secondary complications caused by ordinary bacteria are likely to occur during the course of the common cold. These may be helped by the use of antibiotics."

P.S. In two other recent studies, researchers felt that the early nasal symptoms might be helped by antihistaminics but did not feel that the course of the cold was otherwise altered.

* From Bulletin to School Nurses, Denver, Colo., Assembled by Drs. Doster and Knopf.

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EDITORIAL

The 1950 Convention: The American School Health Association has had a splendid past and its future looks bright. That was evident to anyone who attended the 1950 annual meeting of the Association in St. Louis the week of October thirtieth. But the future will be strong only if many more members of the Association are willing to give of their personal time and energy in far greater measure than can be expected of them in the ordinary line of duty. The Association moves on guided by the spirit of Dr. William Howe, founder, and for many years, the executive secretary of the Association, who believed that nothing can be more important than the health and welfare of boys and girls.

Some of the more valuable contributions of the St. Louis meeting are to be found in Dr. Wishik's excellent analysis of the best features of programs administered by Boards of Education as well as by the Official Health departments. Many will be stimulated by this analysis to see how they can inculcate in their local programs the best features brought out in good school health programs everywhere regardless of the administrative unit. Dr. Myer's program on tuberculosis highlighted many years of devoted service to child health and the progress of erasing tuberculosis among school children.

The Howe award was given to Dr. V. K. Volk for his many years of splendid services to the Association and his special contribution to research in the field of diphtheria immunization.

These were but a few of the fine features of our 1950 program. Another year, when we meet in San Francisco, we hope many, especially those in the western half of the country, can meet with us and become acquainted.—*Gertrude E. Cromwell.*

* * * * *

ABSTRACTS AND NOTES

The March of Dimes,—Crises are not new to the National Foundation, but this year we are faced with a dual dilemma. On the one hand, the nation now has the largest number of polio patients in history, and on the other, the public is not fully conscious of the seriousness of the financial situation thus created.

That is why we most urgently seek the help of the nation's Magazines this year in conveying to the public the urgency of the 1951 March of Dimes campaign January 15-31.

There is reason for the public's lack of awareness of the real polio situation. The nation experienced its worst polio epidemic in 1949. Therefore any incidence less than 1949's appeared to be "light." Added to this, 1950 started out to be a relatively "light" polio year, but is finishing as the *second worst* ever recorded.

The situation is even more serious than that. Last September 5th, Howard Blakeslee of the *Associated Press* wrote, "This year America has an all-time record polio hangover. The hangover is about 30,000 cases still under medical care from last year and before that."

We speak of cases and figures, but what of the human equation? Turnley Walker, in his August Book of the Month Club selection, RISE UP AND WALK, describes a hospital visit by his wife after he had been stricken with polio:

". . . Your wife appears carrying a miracle in the shape of a brisk white business envelope. She reads it to you, and gratefulness at what it says makes you weep together . . . The letter says that the National Foundation will stand behind you . . . It lets you KNOW that you are not lost forever, but only out of circulation for a while . . ."

This is the example the National Foundation has set itself—this is what it must do for present and future patients.

* * * * *

Tularemia in Illinois,—Approximately 90 per cent of the cases, comprised mainly of hunters, butchers and housewives, have been traced to the skinning, dressing and handling of infected wild rabbits. Many other animals, as well as birds, have been found to harbor the bacteria and constitute sources of human infection. Included among these are squirrels, skunks, opossums, woodchucks,

foxes, cats, sheep,, deer, quail and pheasants.

The organisms of tularemia gain entrance into the body through an abrasion in the skin or through the mucous membrane. The onset of the disease is sudden, accompanied by chills, fever, headache and general prostration. Usually an ulcer appears at the site of entry of the organism, and with it a swelling of the lymph glands draining the area.

The severe symptoms of tularemia commonly persist for two or three weeks. Due to the debilitating effects of the disease, convalescence is slow, requiring a period of two or three months. Complete recovery is best assured with early medical care. Streptomycin has been found beneficial in the treatment of the disease.

Unfortunately, no effective vaccine for the prevention of tularemia has been developed. The disease can be avoided, however, by the observance of a few simple precautions. The following suggestions are for the benefit of hunters, housewives and all other persons who may be in danger of exposure to the infection:

1. Avoid shooting or handling rabbits that are inactive or appear ill.
2. Destroy all rabbits whose internal organs are studded with small white spots — they may have tularemia.
3. Wear rubber gloves when dressing wild rabbits.
4. Thoroughly cook all wild game, especially rabbits.
5. Avoid the bites of ticks and fleas.
6. Do not drink water from streams.

From Illinois Health Messenger.

* * * * *

REPORTS

November 9th, 1950

Following are brief summaries of my reports to the Governing Council:

I. Report as Representative on the National Conference for Cooperation in Health Education:

1. A meeting was held last December at which it was unanimously voted that these meetings were desirable and helpful. It was decided in the future to meet once a year. The next meeting will be a two-day meeting in January to be held in Cleveland, Ohio.

2. A plan has been developed in which new materials produced by any of the constituent agencies are now being sent to all of the other agencies. Materials coming to this Association are forwarded to the Editor.

3. The National Conference, at its last meeting, explored various desirable activities and some of the groups volunteered to

undertake activities along the line of their special interest.

4. The vision studies in St. Louis, which are now being finished, were started out of a discussion of the National Conference for Cooperation in Health Education. Dr. Franklin Foote is in charge of these studies.

5. A yearbook will soon be issued by the National Conference giving the nature of each of the professional and voluntary health agencies on the national level. Copy for the description of this Association has been approved by the President and returned to the Editor.

II. Report on Possible Future Activities:

May I raise the question as to whether this Association could profitably have a committee on the mental health aspects of school procedures? Such a committee, if formed, should relate itself to the work of other professional agencies in this field to such extent as other agencies are at work on this problem. Two reasons suggest themselves for organizing such a committee. One is the nature of this organization and the benefits which might accrue from a study of this problem by medical and other professional school health workers. The second is the conflict which exists at present as to what contributes to the mental health of students. One school of thought believes that this is a free, democratic, competitive society and that we should train children to accept both success and occasional defeat without becoming unduly disturbed. They believe that we should teach children that every child cannot succeed in everything, but that there are some things at which every child can succeed. The other school of thought believes that children should be protected from a sense of failure and that we should so completely protect children that there is no possibility of having a disturbed child. This is illustrated by the tendency to give S and U grades on the basis that every child who is doing as well as the teacher thinks he can will receive S and any child who is not doing as well as the teacher thinks he can is to get U or Unsatisfactory. This means that the dullest child in the class might get S and the brightest child in the class might get U. There seems to be no consideration of the danger to mental health when children realize that their only job is to please a "higher-up," namely, the teacher, and that they are in the hands of the teacher. Another angle of this philosophy is reflected in the educator who recently said to me that children on the playground learn that some boys can run faster than others and that that is disturbing and undesirable. He says, however, that they have found no way to prevent competition on the playground so far. Clair Turner, Ed. M., Dr. P. H.

NOTICE

A few months ago the publication office of the *Journal of School Health* received a request — and payment — for two copies of the March, 1949, issue. The request carried the name of Miss Pauline S. Riley, but no address, not even the name of the state. Send missing data and get the *Journal.* CHK.

* * * * *

REVIEW

Tulare County's Health Instruction Guide for Secondary School Teachers,—The Health Instruction Guide for Secondary School Teachers prepared and published under the leadership of J. Post Williams, Superintendent, Tulare County Schools in cooperation with 27 local and state organizations will be available in December.

This publication which was authored by Dr. O. E. Byrd, Tulare County School Health Consultant of Stanford University and edited by Dr. Burt M. Kebric, Coordinator of Health Education, Tulare County Schools will be distributed to all secondary schools in this area.

This book is a continuation of the Health Instruction Guide for Elementary Schools ($1.55) which was published in January and has already had two printings. Requests for it have been received from UNESCO in Paris, China, Japan, Canal Zone, South America and thirty-four states in this country.

These guides were cooperatively prepared at the request of educators and citizens in Tulare County to give teachers a flexible health pattern of what to teach and how to teach it in order to assist the local students in the development of effective health behaviors. *They represent one of the first attempts to develop cooperatively an integrated program of health instruction on the county level from kindergarten through grade* 14 *based upon extensive studies of pupil and community needs and interests.*

Practical features of this book are a summary of the basic facts with teaching outlines for the 33 health problems covered and a detailed explanation of applied teaching methods.

Copies for those outside of Tulare County may be obtained for the cost price of $4.50, by writing to J. Post Williams, Superintendent, Tulare County Schools, Courthouse, Visalia, California.

* * * * *

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